Clinical Practice Guidelines: Obstetrics/Physiological cephalic birth

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<tr>
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<tr>
<td>Purpose</td>
<td>To ensure consistent management of Physiological cephalic birth.</td>
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<td>Scope</td>
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Normal birth is defined by the World Health Organisation as:

- spontaneous in onset
- low-risk at the start of labour
- remaining low-risk throughout labour and birth
- the newborn is born:
  - spontaneously
  - in the vertex position
  - between 37 and 42 completed weeks gestation
- after birth, the woman and newborn are in good condition.\(^1\)

**Clinical features**

**Signs of imminent birth**

- loss of operculum plug – when the cervix dilates, the mucous plug (‘bloody’ show) dislodges from the cervical canal (may have occurred days before)
- increasing frequency and severity of contractions with an urge to push, or open bowels
- membrane rupture (this may not occur and active membrane rupture will be required if the head has been delivered with the membrane intact)
- bulging perineum
- appearance of the presenting part at the vulva.

**NOTE** – If birth is imminent due to trauma, refer to CPG: Trauma in pregnancy.

**Risk assessment**

Gaining adequate antenatal history may pre-empt complications associated with birth, including:

- gestational diabetes (macrosomic baby, shoulder dystocia risk)
- mal-presentation
- multiple pregnancy
- pre-eclampsia
- placenta praevia
- perinatal substance use
- history of obstetric or gynaecological disorder or emergency.

Ensure an aseptic technique and always use appropriate infection control measures.
**Additional information**

- Support the mother to find a position of comfort (lying lateral, or on all fours).
- Following spontaneous rupture of membranes the vagina should be visually inspected for cord presentation or prolapse – ask the mother to feel for the cord.
- Support controlled breathing through-out the contractions – encourage the mother to push with each contraction as she feels the urge.
- Manage delivery in accordance with CPP: Physiological cephalic delivery.

**Care of the newly born (postnatal care):**

- Thoroughly dry the newborn, wipe the eyes and assess the newborn’s breathing.
- If the newborn is crying or breathing effectively (chest rising at least 30 times per minute) leave the newborn with the mother. If the newborn is not breathing effectively, immediately refer to CPG: Resuscitation – Newly born.
- Ensure the newborn is kept warm and heat loss is minimised – if required use the baby blanket and beanie from the QAS ‘Maternity Pack’.
- Assess neonatal and maternal observations:
  - Neonatal observations: APGAR (at 1 and 5 minutes), HR, RR, Temp and muscle tone – every 15 mins
  - Maternal: HR, BP, Temp, PV loss and fundal check – every 15 mins
- Cord clamping and cutting:
  - Late cord clamping and cutting (3–5 minutes following birth) is recommended for all births, while initiating simultaneous essential neonatal care. Immediate cord clamping (< 1 minute following birth) should only be performed if the newly born is asphyxiated and needs to be moved immediately for resuscitation.[4,5,6,7]
  - Some mothers may request the cord remain intact with placenta attached (not clamped or cut). This request should be respected unless the newborn is required to be moved for resuscitation.
- If the mother consents, clamp the cord at 10, 15 and 20 centimetres from the newborn and cut between 15 and 20 centimetres.
  - Provide a safe warm environment with uninterrupted skin to skin contact. Encourage breast feeding to promote the production of maternal oxytocin.
**Additional information (cont.)**

**Active management of the third stage of labour (oxytocin administration)**

a) Promote maternal production of oxytocin by providing a safe, warm environment with uninterrupted skin to skin contact between mother and baby, and encourage breastfeeding.

b) Administer oxytocin (refer to DTP: Oxytocin).

c) Observe for and confirm signs of placental separation:
   - The uterus rises in the abdomen
   - The uterus becomes firmer and globular (ballotable)
   - Fresh show/trickle of blood
   - Lengthening of the umbilical cord.

d) Delivery of the placenta.
   - Assist the mother to birth the placenta by her own efforts. Encourage her to adopt an upright position, bearing down to expel the placenta; OR
   - Guard the uterus by placing one hand suprapublically and applying steady controlled cord traction until the placenta is visible. Support the birth of the placenta and membranes by gently twisting to strengthen the placenta and limit the chance of retained products – do not apply increased traction if resistance is felt.

e) Retain the placenta for visual inspection by the midwife and/or doctor.

f) Complete a fundal assessment:
   - If the uterus is soft – massage the fundus until it is firm and central. Consider asking the mother to pass urine, as a full bladder can inhibit the contraction of the uterus. Fundal massage is only to be performed following delivery of the placenta.
   - If the uterus is firm – do not massage the fundus as this may cause further bleeding and pain for the mother.

g) Assess and estimate blood loss (normally around 200–300 mLs).
Physiological management of the third stage of labour (refusal of oxytocin)

a) Promote maternal production of oxytocin by providing a safe, warm environment with uninterrupted skin to skin contact between mother and baby, and encourage breastfeeding.

b) Assist the mother to birth the placenta naturally by her own efforts. Encourage her to adopt an upright position, bearing down to expel the placenta.

c) Do not apply cord traction.

d) Once the placenta has been delivered, retain for visual inspection by the midwife and/or doctor.

e) Complete a fundal assessment:
   - If the uterus is soft – massage the fundus until it is firm and central. Consider asking the mother to pass urine, as a full bladder can inhibit the contraction of the uterus. Fundal massage is only to be performed following delivery of the placenta.
   - If the uterus is firm – do not massage the fundus as this may cause further bleeding and pain for the mother.

f) Assess and estimate blood loss (normally around 200–300 mLs).
Transport to hospital
Pre-notify as appropriate

Continually reassess during transport

Patient in labour?

Signs of imminent birth?
- allow mother to assume a comfortable position
- prepare equipment
- consider analgesia

Cord prolapsed?
Manage as per: CPG: Cord prolapse

Breech presentation?
Manage as per: CPG: Breech birth

Ensure controlled birth of head

Cord loop around neck? (nuchal cord)
Manage as per: CPP: Nuchal umbilical cord

Shoulder obstructed?
Manage as per: CPP: Shoulder dystocia

Baby birthed

Is the amniotic fluid clear?
- good breathing/crying
- good muscle tone AND
- HR > 100
Manage as per: CPG: Resuscitation – Newly born

Consider:
- Oxytocin

Conduct post-birth assessment and cares:
- Dry baby
- Maintain warmth
- Provide maternal and baby skin to skin contact
- Clamp and cut the cord, when stops pulsating
- Manage third stage of labour
- APGAR score at 1 & 5 mins
- Encourage breastfeeding

Note: Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.